Community First Health Plans, Inc. Special Investigative Unit

A Texas Medicaid Managed Care Organization

Results in Brief

Why OIG Conducted This Audit

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of SIU activities at Community First Health Plans, Inc. (Community First), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

Community First's 2019 total enrolled member months was 1,385,589 for Medicaid and 208,698 for CHIP. In 2020, Community First's total enrolled member months was 1,410,769 for Medicaid and 186,461 for CHIP.

Summary of Review

The audit objective was to determine whether Community First complied with selected state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

The audit scope covered SIU activities in state fiscal year 2020. The scope also included a review of significant controls and control components within the context of the audit objectives including the prevention, detection, investigation, recovery (as applicable), and reporting of fraud, waste, and abuse allegations through the end of fieldwork in February 2022.

Conclusion

Community First Health Plans, Inc. (Community First) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on special investigative unit (SIU) activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC).

During the audit period, Community First met certain requirements related to staffing the SIU, training, monitoring service patterns, and remitting funds recovered.

Key Results

Community First has opportunities to improve the timing and documentation of its SIU efforts in both preliminary and extensive investigations, reporting to OIG, and its fraud, waste, and abuse training. Specifically, Community First did not consistently:

- Ensure preliminary investigations contained required elements and met required timelines. Eight of the 23 (35 percent) preliminary investigations were not completed within the 15-working-day requirement. Those 8 preliminary investigations were closed, on average, 73 working days from when the allegation was reported to Community First. Furthermore, 22 investigations were missing at least one required element including those Community First indicated it had completed on time. Conducting timely preliminary investigations and performing all required elements helps ensure Community First timely identifies potential fraud, waste, and abuse, Medicaid overpayments, and appropriately reports SIU activities.
- Include the date of the allegation on its log of incidences of suspected fraud, waste, and abuse. Community First stated it used the date the case was opened as the date the allegation was received in its incident log, regardless of whether the investigation was opened immediately. Not documenting when the allegation was received could impede Community First's ability to complete preliminary investigations within the required timeframe.

Background

HHSC requires MCOs to have an SIU to investigate potential fraud, waste, or abuse by members and health care service providers.

Recommendations

Community First should implement processes, when applicable, to ensure it:

- Timely completes and sufficiently documents all required elements of preliminary investigations.
- Records the date the allegation of fraud, waste, or abuse is received.
- Selects at least the minimum sample sizes of members or claims required for investigations.
- Meets and adequately documents the required timelines for elements of extensive investigations.
- Logs all cases and ensures it reports all opened investigations to OIG.
- (a) ensures all possible fraud, waste, and abuse findings are referred to OIG as required, and remit half of the money collected from such referrals, (b) documents its rationale when it determines that the results of an investigation do not indicate possible fraud, waste, and abuse, (c) re-audits providers given education as the result of an extensive investigation, and (d) submits referrals within 30 working days.
- Provides fraud, waste, and abuse training to employees and subcontractors directly involved with any aspect of Medicaid or CHIP within 90 days of employment and annually.

Management Response

Community First agreed with the audit recommendations and indicated corrective actions would be implemented by June 2022.

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- Ensure sample sizes for extensive investigations met requirements. Texas Administrative Code requires Community First to select certain minimum sample sizes to review. Limiting sample sizes can prevent Community First from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider.
- Meet or sufficiently document all timeline requirements for extensive investigations. Community First has required timeframes after completion of a preliminary investigation to select a sample of claims for review, request records and encounter data, and review the records and encounter data. When fraud, waste, or abuse is suspected, delays can impair Community First's ability to mitigate fraud, waste, and abuse within the Medicaid and CHIP programs.
- Include all opened investigations on the Monthly Open Case List Report submitted to OIG. Community First conducted 28 SIU investigations in 2020 that it did not report to OIG on the monthly report. In addition, a case that OIG referred to Community First was neither assigned a case number nor added to the report. OIG uses information provided by MCOs to analyze potential fraud, waste, and abuse trends. Inconsistent reporting by MCOs impairs OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse.
- Refer all extensive investigations and remit half of recovered amounts of possible acts of fraud, waste, or abuse to OIG, as required, or document why those extensive investigations with findings and recoveries were not referred to OIG. Not consistently referring all possible fraud, waste, or abuse also limits OIG's ability to effectively investigate potential fraud, waste, and abuse across the state's Medicaid programs.
- Submit referrals for possible acts of fraud, waste, or abuse to OIG within the required timeframe. During the audit period, Community First referred a total of three cases to OIG. Two of the three cases were referred after 36 and 39 working days, respectively, rather than within 30 working days, as required. Not reporting referrals timely limits OIG's ability to coordinate and oversee efforts to prevent fraud, waste, and abuse throughout Texas HHS programs.
- Ensure staff and a subcontractor completed fraud, waste, and abuse training within the required timeframes. One employee did not receive fraud, waste, and abuse training within 90 days of hire, and another employee hired prior to the audit scope did not receive annual training in state fiscal year 2020, as required. In addition, Community first did not verify that one subcontractor provided its employees with required training. Not ensuring all employees and subcontractors receive required training may decrease the likelihood of detecting potential fraud, waste, and abuse.